STATE MEDICINE AND MEDICAL BUREAUCRACY IN THE HABSBURG MONARCHY: PUBLIC HEALTH, MEDICAL POLICE, AND THE GOVERNANCE OF MEDICAL SPACE WITH A FOCUS ON THE BOHEMIAN LANDS (1740-1820)

Medicina estatal y burocracia médica en la monarquía de los Habsburgo: salud pública, policía médica y la gobernanza del espacio médico en el territorio de Bohemia (1740-1820)[1]

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Abstract

This article examines the emergence and development of Staatsarzneikunde (state medicine) in the Habsburg monarchy between 1740 and 1820, with a specific

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focus on the Bohemian lands. It analyzes how public health reforms, rooted in Enlightenment rationality, were mobilized not only as tools of hygiene and disease prevention but also as part of a broader process of state-building, administrative centralization, and knowledge standardization. The creation of a hierarchical medical bureaucracy — supported by education reforms, legislation, and surveillance — reflected an evolving vision of governance that tied medical knowledge to the state's administrative needs.

Rather than adhering to traditional medical historiography that presents these developments as a linear story of institutional and scientific progress, this study draws on the insights of the sociocultural turn and the cultural history of administration. It emphasizes the negotiated and contested nature of medical reforms, shaped by local conditions, resistance, and the everyday practices of physicians, officials, and patients. Inspired by Foucauldian critiques of medicalization and biopolitics, the article further interrogates how medical knowledge became embedded in bureaucratic power structures and contributed to the formation of the modern state.

By bridging the historiographical divide between older institutional narratives and newer sociohistorical approaches, the article contributes to our understanding of medicine as both a scientific and a political project. It argues that *Staatsarzneikunde* functioned not merely as a medical doctrine, but as an administrative vision — a "cosmology" of health governance that influenced the lived experience of public health far beyond the realm of policy ideals.

Keywords

Public health; Staatsarzneikunde; medical bureaucracy; healthcare reform in Habsburg monarchy; Enlightenment.

Resumen

La evolución de la salud pública a finales del siglo XVIII y comienzos del XIX suele interpretarse desde los ideales de la Ilustración, con énfasis en la higiene, la salud pública y la policía médica *(medizinische Polizey)*. Inicialmente vistas como una fuerza progresista, estas ideas fueron reevaluadas tarde por historiadores en el siglo XX, quienes destacaron las dinámicas de poder y las desigualdades en el acceso a la atención médica. Este cambio en la historiografía trajo un nuevo enfoque hacia individuos marginados y problemas sociales, todos vistos a través del prisma de la medicalización. En la monarquía de los Habsburgo, María Teresa y José II impulsaron reformas para centralizar y modernizar el Estado, lo que afectó a la salud pública y a la educación médica. Muchas de estas medidas surgieron en respuesta a las debilidades reveladas por las guerras de Sucesión Austríaca (1740-1748). En el ámbito, estas reformas culminaron en la creación de la Staatsarzneikunde, disciplina que

integraba la policía médica, la medicina forense y la administración sanitaria. Su incorporación a los planes académicos buscaba preparar a los médicos para funciones dentro del aparato estatal y fortalecer la gestión pública de la salud. Francisco II continuó con estas reformas. La implementación práctica de estas reformas dependía de un sistema burocrático robusto, apoyado por la legislación y una red jerárquica de Administración médica. A pesar de las críticas y desafíos, estas medidas marcaron un paso significativo hacia un sistema de salud moderno, reflejando una compleja interacción entre la ciencia médica y el poder estatal.

Palabras clave

Salud pública; medicina estatal; burocracia médica; reforma sanitaria; monarquía de los Habsburgo; Ilustración.

SUMARIO

I. INTRODUCTION

The development of public health systems in the eighteenth century cannot be understood solely within the boundaries of individual monarchies. Rather, it formed part of a broader transformation across Europe, in which different political regimes responded to medical challenges with varying degrees of state involvement. In the German-speaking territories—politically fragmented yet intellectually interconnected — the rise of *Staatswissenschaften* (sciences of the state) led to the emergence of what has been called "state medicine," wherein health policy was embedded in broader strategies of bureaucratic state-building. As Michel Foucault (2002: 90-106,134-156) has noted, medicine during this period became a form of governance — an instrument for organizing bodies, behaviours, and populations. Unlike in France or Britain, where health initiatives often stemmed from urban municipal leadership or some kind of market dynamics, German reformers framed medicine as a central component of state functionality, aiming to manage not only disease but also the socioeconomic conditions underlying it.

While monarchies like France or Russia centralized health control under state or municipal authority, other polities, particularly republics such as the Dutch Republic or the city-states of Italy (e.g. Venice or Florence), maintained decentralized and locally driven health institutions. In Venice, the *Magistrato alla Sanità* had been active since the fifteenth century and remained one of the most structured public health offices in Europe, focusing on quarantine enforcement or epidemic surveillance. In the Dutch Republic, where urban autonomy was strong, cities like Amsterdam and Leiden managed their own health infrastructure through civic, charitable, and often confessional institutions. These cases demonstrate that health politics in the eighteenth century took divergent institutional forms depending on political culture and administrative tradition. Against this backdrop, the Habsburg project of standardizing public health — imposing a unified and centrally coordinated system across a diverse and multi-ethnic empire — emerges as both historically distinctive and deeply ambitious. Its scope, rationalized structure, and

integration of medical policy into Enlightenment absolutism make it a crucial case for understanding the links between medicine, power, and imperial governance.

In the history of medicine, the issue of public health has often been viewed through the conceptual lens of Enlightenment. After all, it was during the Enlightenment that hygiene, public health, and medical police (*medizinische Polizey*) emerged as important subjects in debates about governance and the functioning of a "civic" (*bürgerlich*) state. The rhetoric used by Central European and French physicians of late eighteenth and early nineteenth centuries was later often uncritically adopted by historians of medicine and petrified in the new field of the history of medicine during the first half of the twentieth century. The introduction of public health measures was portrayed as a struggle between light and darkness, as a victory of knowledge over ignorance, a gradual triumph of civilisation, and a hallmark of modern society.

This perception had undergone a gradual but significant change in connection with a general shift in the historiography of medicine and science in the 1960s and 1970s.[2] At this time, the "new" social history of medicine focused on the issue of power, especially in relation to the inequality of actors in terms of access to healthcare, and historians started to question who had the right to be the subject of the history of medicine. Former heroes became villains and people at the margins of society, i.e., the troubled individuals and people who did not fit social expectations, took their place in the spotlight of interest of historians inspired by the sociocultural turn.[3] In an effort to emphasise the need to transform the history of medicine, numerous historians have denounced the positivist approach of their predecessors and vehemently criticised the heroization of famous physicians while neglecting both the desirability of plurality of approaches and debates about the meaning and direction of research in the history of medicine that were also taking place. They sometimes used a caricature of the "old" history of medicine (written mainly by physicians) to justify their new approach. As Huisman and Warner (2004: 2) note, historians of medicine in the 1970s to 1990s frequently resorted to trouncing the strawman of older medical history in order to forge and consolidate a new identity for the field and for themselves. History endorsed a (new) strategy: it was viewed as an

[2] This transformation of the historiography of medicine related to changes in historiographical approaches in general. The social and subsequent cultural turn introduced new approaches to historiography, inspired by anthropology, sociology, linguistics, and literary theory. See, e.g., Burke (1990); Iggers (1993); Storchová (2014); Jordan (2021).

[3] Nye (2003: 116).

agent of a new mission, which by criticism of medical practice could ultimately bring about social change.

New topics came to the fore. Many of them were related to the attitude of medicine towards socially problematic phenomena such as suicide[4], madness[5], or the control of sexuality[6], that is, topics which were viewed in the 1960s and 1970s as closely related to the medicalisation of society.[7] Historians of medicine thus turned their attention to subjects whose perception, in the course of the eighteenth and nineteenth centuries, had transformed from being viewed as sinful, through classification as pathological social behaviour (criminalisation), all the way to being viewed as medical issues, in particular as medical pathologies, disorders that could and should be treated.[8]

One of the most influential critics of medicalizing practices within the history of medicine was, undoubtedly, Michel Foucault, whose critique was firmly grounded in historical analysis. Foucault's understanding of medicalization evolved significantly over the course of his intellectual career. His early works

4 Minois (1995); Lind (1999, 2004); Lorenz (1999).

5 Foucault (1961); Porter (1987); Scull (2015).

6 Laqueur (1990).

7 The concept of medicalization was first introduced by Talcott Parsons in a positive sense, as an integral component of the functioning of modern society. However, it gained broader critical traction in the 1960s and 1970s as a response to the growing influence of the medical profession and its capacity to redefine various forms of deviance as medical problems. This shift is closely associated with the anti-psychiatry movement and thinkers such as Thomas Szasz and Ivan Illich, who offered sharp critiques of medical authority. Peter Conrad and Joseph Schneider attempted to provide a systematic framework for understanding medicalization in their book *Deviance and Medicalization*, where they introduced a sequential model as an analytical tool for examining medicalizing processes. Conrad and Schneider (1980). During the 1970s and 1980s, diverse approaches to the concept of medicalization emerged. Irwing Zola interpreted it as a labeling process based on the binary categories of healthy/sick, extending into increasingly broader areas of human life. A more moderate interpretation is offered for example by Paul Weindling, who defines medicalization as the expansion of scientific and rational meanings into various domains of human activity. Already in the 1980s, the concept of medicalization began to face growing criticism. Some scholars, such as Nikolas Rose, questioned the idea that medical knowledge can be treated as a single, unified system. According to this critique, it is too simplistic to view the political role of medicine only as a form of social control. At the same time, earlier criticisms had already been directed at the social constructivist approach taken by authors such as Eliot Freidson, particularly for downplaying the importance of scientific knowledge. Bury (1986: 137-169); Liepoldová (2024: 52-54).

8 Conrad and Schneider (1980).

position him closer to the more radical stance of thinkers such as Ivan Illich. However, as scholars like Deborah Lupton (1997: 94-110) and Robert Nye (2003: 117-119) have shown, his later writings reflect a more nuanced and complex interpretation of medicalization.

In his lectures delivered in Brazil, Foucault addressed various dimensions of the medicalization process. Contrary to assumptions that medicalization first targeted the working population in Britain, Foucault argued that its primary focus was initially the state itself — particularly within the German cultural sphere. Medicalization took on different forms in Germany, France, and Britain, shaped by the distinct political and economic contexts of each region. In the German states, where the medicalization of institutions and the development of public health administration became central strategies, a new form of "social medicine" emerged as a response to specific economic stagnation. Unlike in economically and politically advanced nations such as France or Britain, the push for state-controlled health systems and collective care originated in politically fragmented Germany. There, the so-called "sciences of the state" (*Staatswissenschaften*), including medicine, were intended to form the bureaucratic foundation for a structured network of governance that would secure the internal and external position of the German state.

Following Foucault's contributions, historians and scholars in the history of medicine further refined the concept of medicalization. Influenced by his work, historical approaches began to emphasize the contextual specificity and variability of medicalization processes, moving away from overly rigid or totalizing definitions.

This reconceptualization of public health history also paved the way for new empirical and historiographical directions. A notable example from the German-speaking scholarly environment — particularly relevant for the context under discussion — is the work of Francisca Loetz, who draws on the German tradition of social history. Her research places stronger emphasis on medical practice itself and explores both the differences and commonalities within medical systems through the lens of lived experience, a perspective inspired by the sociological concepts of Georg Simmel. Loetz (1993) demonstrated this approach in her analysis of medicalization processes in the region of Baden at the turn of the eighteenth to the nineteenth centuries. Her work exemplifies a broader historiographical shift away from the "radical" models of medicalization developed by social scientists in the 1960s and 1970s, toward more empirically grounded, context-sensitive frameworks.[9]

[9] The theme of medicalization has also resonated in Czech historiography in recent decades. A prominent example is Daniela Tinková, who has repeatedly employed the

Critiques and subsequent refinements of the concept of medicalization also led to calls for a shift in perspective. Particularly within sociology, but increasingly also among historians of medicine, voices emerged advocating for a history "from below" — a perspective that seeks to recover the patient's experience (Jewson 1976; Porter 1985; Duden 1987) and to situate medical practices within broader social and cultural contexts. This turn towards the lived experiences of patients and the social embeddedness of medical practices opened the door to interdisciplinary approaches that further challenged the universality of biomedical knowledge.

One of the most influential contributions to this line of thinking came from medical anthropologist Arthur Kleinman, who introduced the notion of *cultural systems of health and illness*.[10] His work thus helped reframe medicine as a culturally embedded practice and laid the groundwork for later discussions about the plurality and diversity of medical cultures across societies.

In the context of the history of medical administration, Lukas Lang has drawn on insights from the cultural turn. His research focuses on the dynamics of the development of health policing in the Habsburg Monarchy, particularly in Austria. Rather than interpreting this process as a purely top-down implementation of state authority, Lang highlights the complex interplay of negotiation, adaptation, and reflection that occurred across various administrative levels. Central to his approach is an effort to reconstruct lived administrative practice, with a particular emphasis on the processual and variable nature of responses to health-related issues. These responses, as Lang shows, were not uniform, but reflected broader political and administrative transformations within the Habsburg state. By foregrounding these dimensions, Lang contributes to a more nuanced understanding of medical governance as historically contingent and embedded in the evolving structures of imperial rule.

In the following, I investigate the emergence of state medicine, *Staatsarzneikunde*, in Central Europe, especially in the Habsburg monarchy

concept in her analyses. Tinková draws inspiration from Michel Foucault's theoretical insights, integrating them into her interpretations of Enlightenment-era governance, body politics, and the regulation of deviance. See Tinková (2012, 2021)

[10] This concept serves as an analytical tool for understanding how beliefs, knowledge, assumptions, and behaviours related to health and illness are shaped within specific cultural contexts. Kleinman emphasized that these systems include not only local explanatory models and healing practices, but also the ways in which medical interventions are interpreted, adapted, or resisted by patients and communities. See Kleinman (1978, 1980)

with a focus on the Bohemian Land. The nascent *Staatsarzneikunde* reflected the growing trend of a strong connection between the state, universities, the medical profession, and the public sphere. As the name itself suggests, it was about the interconnections between medicine and the state. Although physicians did not perceive the term uniformly, and whether and how the term *Staatsarzneikunde* should be used at all was, as we shall see, debated in medical journals,[11] many physicians in the late eighteenth century understood it to mean the union of medical police *(medizinische Polizey)* and forensic medicine *(gerichtliche Arzneikunde)*. As Núñez, Rasimoğlu, and Martykánová argue in their introduction to this special issue, a closer investigation of this connection between state and medicine in the absolutist monarchies of Central Europe is crucial especially in countries where historians have systematically linked the emergence of public health policies and other interventionist measures to the "liberal state" and parliamentary constitutionalism.

In the Habsburg Empire, the reign of Empress Maria Theresa (1740-1780) and her son Emperor Joseph II (1780-1790) was characterised by far-reaching reforms aimed at strengthening the state administration, centralisation of power, and modernisation of the monarchy. Early on, Maria Theresa's reign was affected by the Wars of the Austrian Succession (1740-1748), which led to the loss of most of Silesia and exposed numerous weaknesses in the functioning of the monarchy. To maintain control over her vast hereditary lands, the empress initiated a series of reforms. Many of those reforms aimed at the modernisation and centralisation of state administration: their goal was to create a unified and efficient bureaucracy that would enable oversight of all parts of the empire, including even the most distant provinces. Reform of the army, agrarian policy, education and healthcare also received considerable attention. Joseph II, her son, co-ruler since 1765 and emperor in his own right from 1780 to 1790, continued these reforming efforts. He deepened the centralisation tendencies and focused on the secularisation of the state. Not too surprisingly, the reformist absolutism of the two monarchs met with the opposition of both the nobility and the Church. The brief reign of Joseph's brother Leopold II (1790-1792) was thus marked by attempts to ease tensions between the state and the estates by moderating and revising Joseph's reforms.

The French Revolution and subsequent Napoleonic Wars had a profound impact on Austria. The high costs of the wars and the territorial losses the monarchy had sustained required changes in tax administration and a

[11] Among other things because the terms *Arznei* and *Arzneykunde* were in the second half of the eighteenth century quite commonly used in the sense of medicine, i.e., not only to mean the knowledge of medicine (i.e., as pharmacy and pharmacology).

reorganisation of the army. The government of Francis II, the eldest son of Leopold II, therefore focused on consolidating the centralisation and bureaucratisation of the state. This was also reflected in healthcare reforms aimed chiefly at increased state oversight of health institutions, medical education, and medical practitioners. The introduction of *Staatsarzneikunde* as a mandatory subject at Habsburg universities was a symptom of contemporary efforts to introduce bureaucratic control mechanisms.

When discussing the transformations of public health in the eighteenth century within the Habsburg Monarchy, it is essential to clarify that the term "Habsburg Monarchy" should not be understood as denoting a unified or homogeneous entity. Although Enlightenment reforms initiated from the Viennese centre sought to achieve administrative unification and bureaucratization, their implementation and impact varied significantly across the constituent lands of the Monarchy, particularly in Hungary. In many (peripheral) regions, traditional estate-based structures and historically rooted forms of local governance played a considerable role, often obstructing the direct application of central regulations. Regional disparities were thus not only geographical but also institutional and cultural in nature, and must be taken into account when assessing the effectiveness and trajectory of reform processes.

These peripheral divergences within the Monarchy manifested themselves both in the pace and in the form of adopting health-related reforms. In the Kingdom of Croatia and Slavonia, for instance, a key moment came with the establishment of the Royal Council in 1767, which became an instrument for the enforcement of Viennese policies.[12] In some parts of Hungary, by contrast, county physicians (*comitatus medici*) played a decisive role; their everyday practices significantly shaped the degree to which hygienic and medical measures were accepted and applied within local communities.[13] The following text, however, will focus primarily on the Austrian and the Bohemian context within the Habsburg Monarchy.

The term *Staatsarzneikunde* first appeared in German in print in 1784, in the title of Christian Friedrich Daniel's *Entwurf einer Bibliothek der Staatsarzneykunde oder der gerichtlichen Arzneikunde und medicinischen Polizey von ihrem Anfange bis auf das Jahr 1784* (Outline of a Library of State Medicine or of Forensic Medicine and Medical Police Since Its Inception Until 1784).[14] In

[12] A key point of reference for understanding the context in this area is the work of Ivana Horbec. See Horbec (2015, 2018).

[13] See also the excellent works of Lilly Krász for further insight (Krász, 2012, 2013).

[14] Daniel (1784).

this synthetic work, Daniel describes a link between the two disciplines mentioned in the second part of the title, emphasising that they both best served the interests of the state, albeit from different perspectives. This is also how the enterprise was understood by Daniel's medical contemporaries who endorsed the idea and tried to mould medical police and forensic medicine into a single discipline. This is the context in which Christoph Knape, professor of anatomy at the University of Berlin, spoke of "his late friend" Daniel in his *Kritische Annalen der Staatsarzneikunde*.[15] Johann Peter Frank, an eminent Austrian physician considered by his contemporaries (as well as many historians of medicine researching the history of public health in Germany in mid-twentieth century) to be the "founder" of public health, also speaks of Daniel's primacy regarding this concept of state medicine.[16]

Nevertheless, the two disciplines (forensic medicine and medical police) were viewed as closely related even before the publication of Daniel's *Library*. In 1782, there appeared the first number of a new journal dedicated to the two disciplines, the *Magazin für die gerichtliche Arzneikunde und medizinische Polizei* (Magazine for Forensic Medicine and Medical Police), whose chief editors were the German physicians Konrad Friedrich Uden and Johann Theodor Pyl.[17] It was a professional journal that presented various case studies, interesting examples from practice, reviews, short treatises on specific subjects (e.g., melancholy), and newly published laws and directives. In the same year, the Weimar physician Wilhelm Heinrich Sebastian Buchholz started to publish another periodical on the same subject, the *Beiträge zur gerichtlichen Arzneygelahrtheit und zur medizinischen Polizei* (Contributions to Forensic Medicine and Medical Police; Buchholz, 1782-1792).[18] Both these journals linked medical police and forensic medicine in their titles: it is thus clear that the two concepts were perceived as interconnected.

II. A STATE WITHIN THE STATE

In the eighteenth century, the status of the sciences was undergoing a profound change and medicine, too, wanted to take advantage of new

[15] Knape (1804: xii).

[16] On the other hand, he was one of the physicians who tried to clearly define what the medical police are concerned with, pointing out that their affairs are very different from those of forensic medicine. Frank (1779: Introduction).

[17] Uden and Pyl (1782).

[18] Buchholz (1782-1792).

opportunities that opened up in the fast-transforming scientific, political and economic landscape. At this point, medicine came to see its political potential in the opportunities offered by the new disciplines that focused on individual and collective security. In the first pages of the aforementioned periodical *Magazin für die gerichtliche Arzneikunde und medizinische Polizei (*1782),[19] Konrad Uden writes:

> The purpose of this treatise is to acquaint police superintendents and judges with the principles they should borrow from the art of medicine in order to properly safeguard the welfare of the country and the special rights of its individual citizens (*einzelnen Bürger*),[20] and to enable physicians to lend their hands to the intentions of the courts and chamber colleges with ease, expertise, and skill in public business. If [this writing] could also achieve this, i.e., acquaint the heads of human societies with the necessities of the nature of their subjects, with the causes of their bodily ills, and with the means by which the obstacles to health and wellbeing could be prevented and remedied, it would have achieved all that could be set as its goal.

This goal, however, could hardly be achieved until "one of the brightest names of the present and emerging age" had sanctified it.[21] Uden and Pyl dedicated this issue to Crown Prince Frederick William, heir to the Prussian throne, in the hope that he would use his influence to ensure that medicine received the attention it deserved.

In late eighteenth and early nineteenth centuries, in addition to issues related to public health and forensic medicine, other subjects also started to come to the fore. As noted above, they included the standardisation of medical education and the production of medical knowledge, but also the formation of a hierarchical medical administration supervised by the state, which was often referred to as either *Medicinal-wesen* (the administration of medical affairs) or *Polizey der Medicin*, i.e., "medical police". Its purpose was to facilitate and supervise the implementation of measures aimed at improving public health. Naturally, such efforts to standardise and organise state medical administration

[19] This *Magazin* was a professional journal that contained case studies, various interesting examples from practice, reviews, short treatises on particular issues (for example melancholy), or newly published laws.

[20] The term *Bürger* originally referred to a burgher or a townsman but by the second half of the eighteenth century, its meaning began to shift, gradually acquiring a broader political significance related to citizen and citizenship.

[21] Uden and Pyl (1782: a3-a4).

had been in evidence already in earlier times. In the Habsburg monarchy, they were associated especially with the reforms introduced by Empress Maria Theresa and her personal physician Gerard van Swieten and later by her son Joseph II. What changed at the end of the eighteenth century was the intensity and success with which "medicalisation of the state" was implemented in the German-speaking countries. Related to this was the increasing bureaucratisation and petrification of administrative structures, which took place especially during the reign of Francis II.

The purpose of *Staatsarzneikunde*, "state medicine" was not to care for the sick: it aimed at implementing measures that would protect the population as a whole. It was first and foremost a system of prevention. The firm integration of medicine into state structures was also associated with elevation of the social status of the medical profession and acquisition of political power by the medical community.[22] In the passage above, Uden cautiously suggests that doctors would be happy to "offer their hands to fulfil the intentions of the chamber colleges and courts" and to participate in the exercise of that power — and it seems that these ambitions were successful. The organisation of "state medicine", and especially of medical police, became a political programme and, as such, it was naturally associated with political power. In the course of the nineteenth century, this programme was further implemented and translated into the curricula of medical schools.

This was acknowledged, among others, by Julius Pagel, a physician and historian of medicine at the University of Berlin, who, in 1905, in an introduction to one of his lectures on the history of medicine openly argued that discussions about health issues in the state administration and emphasis on a "healthy state" that was supposed to be secured by medical professionals brought them political power.

[22] This social rise was not a straightforward process. As Hanulík, Rambousková, Núñez-García, Martykánová, and Rasimoğlu show in the special issue DYNAMIS 2021 and other publications (Martykanová and Núñez-García, *Studia historica*), in the mid-nineteenth century the social status of physicians was precarious. This was the case both in Spain, where state intervention and state investment in public health was limited, and in Central Europe, where governments pioneered state intervention and investment in this field. While certain privileged groups and individuals within the medical profession enjoyed high social status, the profession as a whole struggled to place itself firmly among the middle class. In general, the medical profession became firmly middle-class in Europe only in the last third of the nineteenth century. Martykánová and Núñez-García (2000); Núñez-García and Martykánová (2021a,b); Rambousková (2021); Hanulík (2021); Rasimoglu (2021); Rambousková and Martykánová (2023).

> As the importance of medicine or hygiene as the cornerstone of a healthy state life is increasingly recognised, there also increases the need to provide space for parliamentary discussion of health issues. As a result, more doctors have a voice and position in the higher spheres of the state apparatus, not only in the parliaments but also in the ministries of the state.[23]

During the eighteenth century, the goals of state collaboration with physicians had significantly changed. Various regulatory mechanisms aimed at reaching the general population were being established and their implementation was gaining momentum. It was at this time that in the German cultural area collective and social medicine took the shape that is reflected in its form to this day. As a result of changes at the level of states, their governance, their bureaucratic apparatus, as well as due to profound changes in the medical field as such, there emerged an unprecedented opening for mutual cooperation and negotiation between health professionals and state officials.

One can imagine the connections between the state and medicine as taking place on several levels. The historian Catherine Crawford (1993: 1619-1620) proposed a useful classification of relations between legislation and medicine. I want to broaden her proposal and apply it to aspects that need not have been codified in the eighteenth and nineteenth centuries but were nevertheless transmitted as valid by the medical community in the context of teaching. The relationship between the state and medicine took place at the following levels:

- *Legislation pertaining to medical practice*. The state apparatus regulates medicine by imposing rules on all medical professionals. This includes medical ethics, medical standards, licensing, education, penalties for malpractice, etc.
- *The state supports the goals of medicine by issuing relevant legislation*. This applies especially to the legislative basis of preventive medicine and public hygiene: personal safety, sanitary and quarantine measures during outbreaks of epidemics, regulation of food and drink, inspection of living spaces and the environment, regulation and control of water, air, and buildings.
- *Medicine in the service of the justice system*. This includes the detection and prosecution of crimes, criminal activities, and violations of the

[23] Pagel (1905: 75). This passage is followed by a long list of politically successful doctors from various European countries, that is, individuals who held high positions in state administration, frequently outside the medical profession (e.g., in culture).

law (forensic medicine, expert medical opinions in court proceedings).

These three levels also correspond in essence to the three areas mentioned above, which crystallized in Central Europe under the heading of state medicine in late eighteenth and early nineteenth centuries: medical police (*medizinische Polizey*), forensic medicine (*gerichtliche Arzneikunde*) and medical administration (*Medicinal-wessen*).

As noted above, this new apparatus of medical bureaucracy emerged against the backdrop of changes which medicine had undergone in the eighteenth century, when fundamental changes took place both within medical science and in its status and perception. First of all, this was a time of concerted efforts to establish medicine as a science — although opinions regarding what "scientific" medicine should look like had varied.[24] Secondly, we can observe the professionalisation of medicine and associated increase in its prestige. Medicine was changing both in terms of quantity (an increase in the number of doctors and surgeons, establishment of state hospitals and various health institutes) and in terms of quality (standardisation of studies, creation of the medical bureaucratic apparatus, transformation of knowledge-based medicine, etc.). This went hand in hand with changes in the political and economic needs of European states.

The eighteenth century brought about a transformation in the relationship between the doctor, the state, and its population, thus changing the relationship between what one may call individual or private medicine on the one hand and collective medicine on the other.[25] The issue of population health has come to the fore. During the eighteenth century, the professionalisation of medicine was driven by what one may call "the politics of health". The states' need of a healthy population and the still present dangers of devastating epidemics and widespread diseases gave rise to new ways of collective health management. This is how "biopolitics" was born as a set of measures targeting not the individual but the population as a whole. In the words of Michel Foucault, the aim of biopolitics was to capture the global phenomena of life: reproduction, birth, death, and the environment.[26] Again, this is not

[24] Porter (1997: 246-252).

[25] As Michel Foucault points out, private and collective medicine do not stand in opposition to each other, but private medicine is formed in relation to the collective one. One sphere therefore mirrors the other. The mutual relation between a physician and the patient is shaped by collective/social intervention related to the illness or the (sick) individual. Foucault (2002a).

[26] Foucault (1997).

to say that various policies targeting these areas emerged as if out of the blue, but they had never before formed such a significant part the medico-political discourse nor had they been the subject of such concerted efforts to implement relevant measures at the state level. Within health policy, there were several ways in which medicine could affect the health of the society as a whole:

— *Medicalisation of being*. This aspect was mainly concerned with issues related to population maintenance and information about it. Relevant efforts included the new field of "political arithmetic", which used new statistical methods to describe collective phenomena such as birth rate, mortality rate, marriage rate, etc., but also responses to the results of statistical analyses. Reactions to this new information led to various measures aimed, for instance, at regulation of marriage rates, care for infants and new mothers, reduction of infant and child mortality, and care for the physical fitness of (especially) children and adolescents.
— *Medicalisation of living conditions*. This pertained to the regulation of certain basic necessities aimed both at improving their state and education about broadly conceived hygiene. In particular, these efforts regulated living arrangements including heating and lighting, food and drink, but also clothing or the use and hygiene of cookware and tableware.
— *Medicalisation of the environment*. In addition to the necessities of life, dangers associated with various natural phenomena, such as floods or sudden changes in the weather, have come into focus. Also targeted were various dangers associated with the work environment and gatherings of people. This included not only what one would call work safety but also the dangers associated with various forms of popular entertainment or folk superstitions.
— *Prevention*. In Central Europe, prevention was at the heart of the health policy of the state. Prevention included both things not directly related to medical treatment or medicine in general (as in the points above) and the active prevention of diseases, not only epidemics but also contagious diseases, such as rabies or syphilis, or those arising from specific lifestyle or occupation. Prevention was also concerned with protecting (healthy) individuals at risk of death: this included efforts to rescue persons at risk of death (e.g., drowning or suicide), the seemingly dead, and prevention of persons being buried alive. One specific kind of prevention focused on protecting the living from the danger posed by the dead (in consequence of decomposition of bodies and possible associated contagion).

— *Governance and funding*. This area of reforms dealt with political and economic considerations associated with health policies. In order to achieve the objectives outlined above and thus ensure a healthy population and promote "the public good", it was necessary to create an effective system of governance and oversight. In particular, it required the creation of an administrative network focused on healthcare and the creation of health infrastructure in general, meaning the establishment of general hospitals and special-purpose institutions such as foundling hospitals, lunatic asylums, poorhouses, workhouses, and the like.[27]

Staatsarzneikunde was tasked with translating these "medicalisation" targets and measures into practice in the name of the state's welfare. In the late eighteenth and early nineteenth centuries, *Staatsarzneikunde* became a system that brought together all the measures and regulations intended to promote and maintain the general health and welfare of the state's population. The system was also supposed to provide guidelines to medical professionals in the performance of both their medical and administrative duties (especially those associated with the implementation of the various measures).[28]

Not surprisingly, not the entire system as presented in the various manuals and textbooks of *Staatsarzneikunde* or administration of health matters (*Medicinal-wesen*) was implemented in practice. What books and manuals on the subject have described was an ideal to strive towards — and that is also how physicians themselves perceived it. In the words of André Burguière (2009: 217), the system of medical administration as presented by the physicians created a "normative and virtual vision of reality". It was an ideal envisioned or rather created by physicians and among themselves and about themselves, which spread to state officials and subsequently also students. This vision did not correspond to reality, at least not initially. But I believe that through long-term transmission of this "medico-cameralistic

[27] Michel Foucault highlights many of these aspects of "medicalisation" in his texts (Foucault, 2002a, 2002b, 1997, 2008). The form of the system is drawn from various manuals for physicians, surgeons, and state officials in Austria and the Czech Lands, but also from laws and regulations pertaining to health that medical officials were expected to follow.

[28] This is how the *Staatsarzneikunde* is defined by for example Johann Joseph Bernt, professor of state medicine who served as professor at the Faculty of Medicine in Prague in 1808-1813 and later at the Faculty of Medicine in Vienna, where he taught from 1813/14 until his death in 1842 (Bernt, 1816: 1-3).

vision" (or rather "visions", in plural) by teachers to students who went on to become ordinary (non-elite) physicians in both urban and rural environments, many elements of this "cosmology of state medicine" did in fact become part of bureaucratic and medical reality. These new elements could then be subject to negotiation between ordinary people, patients, doctors, bureaucrats, and the state.

In his recent work on the health police in the Habsburg monarchy, Lukas Lang (2021: 174-189) shows that in the late eighteenth and early nineteenth centuries, there was a significant increase in the number of medical regulations issued, and that these regulations were often repeated. Based on further analysis, Lucas concludes that the repeated issuing of norms was not a sign of their ineffectiveness, as many researchers had believed, but rather an effort to clarify, communicate, and correctly — if only partially — implement them in practice.[29] This was doubtless a painful and slow process, not always successful (especially in rural areas), and the ideal envisioned by the physicians and state administration certainly has not been fully achieved. Nevertheless, the systematic transmission of knowledge on "what it should be like" through university education, together with pressure from higher levels of state administration regarding information delivery and adherence to regulations, led to a partial achievement of these goals.[30]

Still, although a comprehensive and functional system for implementing new state regulations concerning medical legislation and population control was an ideal, a vision for the future, the manner in which physicians exerted their influence in creating the system of medical administration had also raised concerns. For instance, Immanuel Kant warned against certain problematic aspects of integration of medical knowledge into state administration. His criticism focused on the limitations of medical knowledge, which was nevertheless affecting increasingly broader areas of human life. Medicine is by its nature an empirical science. It views humans as beings determined by their physiology: it does not consider human actions as acts of free will.

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[29] Pavel Himl (2019) reaches similar conclusions regarding the functioning of police in the Czech Lands.

[30] In the Czech Lands, successfully implemented norms concerned, for instance, the treatment of the bodies of suicides, which included an inspection and autopsy by a physician and a surgeon (Tinková, 2021). Another target that was achieved pertained to the availability of medical care, in particular the presence of a surgeon or physician within a walking distance of at most one hour from each municipality (this was the case at least in the Litoměřice region, which was the subject of a case study (Liepoldová, 2019: 167-168).

Kant's critique was aimed specifically at his colleague from Königsberg, Johann Daniel Metzger, a professor of medicine who specialised in *Staatsarzneikunde*, especially forensic medicine. Metzger, who had long-standing disagreements with Kant, authored numerous treatises and textbooks on forensic medicine, which were used at universities in Prussia but also in the Habsburg Monarchy (including, e.g., Prague). He was also the person responsible for reviewing sections related to *Staatsarzneikunde* in the newly created legal code. The main target of Kant's criticism was forensic medicine. Specifically, Kant questioned the role of physicians as experts for the court. If, he argued, someone caused an accident or committed a crime, one must also consider their mental state and whether the accused was capable of understanding the impact of his or her actions. And, indeed, evaluation of the mental state of the accused by a medical professional was in certain cases mandated by law both in Prussia and in the Habsburg Monarchy but, according to Kant, determination of the capacity for judgment (i.e., whether a person is capable of acting with full reason and based on free will) is an entirely psychological question, and therefore a matter of philosophy and not of medicine. Kant argued that when physicians observe and diagnose their subjects, they are predisposed to seeing them as determined by their physiology. Therefore, physicians do not have the expertise needed to decide whether a crime had been committed of one's own free will.[31]

Physicians, too, were sometimes critical of the new system, as attested by a critical contribution that appeared on 7 May 1812 in Johann Nepomuk Ehrhart's *Medicinisch-chirurgische Zeitung*.[32] In it, an anonymous contributor who described himself as a former physician belonging to the state administration, took the opportunity to review the *Jahrbuch der Staatsarzneykunde* (Yearbook of State Medicine).[33] Before evaluating the specific topics of the yearbook, the reviewer challenged many aspects of *Staatsarzneikunde*, including the term itself. He noted that the term *Arzneikunde*, properly speaking, refers only to the knowledge of medical remedies (and is thus more or less equivalent to pharmacology). Its use in the term *Staatsarzneikunde* therefore confused many physicians by creating a false image of the field. Yet, the reviewer concludes, it was the use of this "questionable term" that allowed

[31] Gerlings (2017: 22-23, 158-164).

[32] "Anonymous review of Jahrbuch der Staatsarzneykunde by Joh. Heinrich Kopp published in Frankfurt am Main in 1811", *Medicinisch-chirurgische Zeitung*, 7-5-1812.

[33] This *Yearbook of State Medicine* was in 1808-1820 published by Johann Heinrich Kopp, a physician in Hanau and a professor at the local lyceum, who later became a medical advisor in the Electorate of Hesse.

Staatsarzneikunde to firmly establish itself in the minds of many physicians and create the idea of the state physician.[34] The reviewer also found problems with bringing together forensic medicine and the health police, two areas of activity that, in his view — and the view of many other physicians — have nothing in common:

> The health police and forensic medicine are not connected by any bond; they have nothing in common. Each has a different purpose, a different forum: the former has a share in administration, the latter does not, and the doctors who administer the former are civil servants, while those who run the latter are not, unless they are also sanitary officers, as is usually the case.[35] To combine the two doctrines and call them state medicine seems to the reviewer as nonsensical as if water and salt works were combined and called state physics, just as the state employees who practice them were called state physicists.[36]

Medicine is a science, and as such a supporting element of state administration. But, the reviewer notes, unlike economics or law — which, according to the anonymous author, deserve to be called "state sciences" — medicine is a science on the same level as physics or chemistry, which are used by the state but stand outside the state structures:

> It is a matter of pride to want to call the part of medicine that is applied to the civil service "state medicine" and doctors in the civil service "state doctors" [...] But, in this context, it must be noted that the exaggerated demands and inappropriate demands and proposals of the doctors themselves are the reason why the health system is not what it should be. They

[34] It is stated in the anonymous review that "the term *Arzneykunde* is questionable because in its true sense, it refers to the discipline that teaches the knowledge of medicinal substances, not to medicine or the medical science. If we were to use the term 'medicine' (*Medizin*) or 'medical science' (*Heilkunde*) instead of *Arzneykunde*, that is, 'state medicine' or 'state medical science' instead of *Staatsarzneikunde*, perhaps only few physicians would be willing to accept it". Nevertheless, as noted above, the term *Arzneikunde* was commonly used among physicians to refer to medicine as such.

[35] The author referred to the functioning of the health administration in Bavaria, but the statement would have applied also to Austria and the Czech Lands. Physicians or surgeons serving, for example, on manors (landed estates) could also give opinions on court cases.

[36] "Anonymous review of Jahrbuch der Staatsarzneykunde by Joh. Heinrich Kopp published in Frankfurt am Main in 1811", *Medicinisch-chirurgische Zeitung*, 7-5-1812.

> want to have their own medical body, medical colleges — they want to create a state within the state. This is contrary to the state establishment! Where do these absurd demands and proposals come from? From the fact that their authors do not understand the pure idea of the state, they do not know the principles of state administration, or they have no experience of medical administration.[37]

III. THE BIRTH OF *STAATSARZNEIKUNDE*

In the German cultural space, the roots of this process of medicalisation aimed at managing and controlling (public) health go all the way back to the seventeenth century. In the aftermath of the Thirty Years' War, there was an increased demand for the concentration and organisation of power within the state. As Meinecke (1929: 161) argues, this was because the traditional state system and the associated customary law had proven to be ineffective and the state defenceless. In the seventeenth century, there thus flourished literature focused on a new concept of *raison d'état*, whose aim was to ensure the stability and security of the state.

In connection with this, new approaches emerged to the administration and organisation of the state: police science and cameralism (*Polizey und Kammeralwissenschaft*), whose aim was to centralise power and strengthen and ultimately stabilise the state. This, the advocates of this way of thinking have argued, would result in an improvement of the general welfare of the population.[38]

From the 1720s onwards, cameralism, i.e., the science of state administration, and with it the science of maintenance of order of the state, i.e. police science (*Polizeywissenschaft*), started to appear in university curricula. In Vienna, cameralism and police science flourished in the 1750s and especially thanks to Joseph von Sonnenfels (1732-1817), they became almost the cornerstone of the state's Enlightenment ideology[39]. In mid-eighteenth century, the Habsburg monarchy, shaken by war, with its treasury nearly empty and its

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37 *Id*.

38 Rosen (1953); Wakefield (2009).

39 Tinková (2022: 143-144). It is interesting to note that von Sonnenfels was born in Nikolsburg/Mikulov in Moravia as the son of Perlin Lipmann, formerly the chief rabbi of Brandenburg. When he was still a child, the family converted to Christianity. Jewish origin thus did not prevent him from becoming one of the most powerful men in the empire.

economy in decline, was indeed in need of reform, even if these reforms were in the spirit of preserving and stabilising the monarchy.[40]

Public health was also discussed in the police science, since a sufficient number of healthy citizens was believed to be the prerequisite for a well-functioning state. From the mid-eighteenth century onwards, one can thus observe in German-speaking lands an increasing emphasis on organised and state-supported healthcare. This interest of the state in the welfare of its citizens led to the notion of a "health police", and that in turn to the concept of *Staatsarzneikunde*, which combined the health police, forensic medicine, and health administration.

In the Habsburg Monarchy, subjects related to public health entered academic curricula in the late eighteenth century, although initially both forensic medicine and health police were taught in the form of optional (extraordinary) lectures. Surviving student records from the 1790s also show that the two subjects attracted different kinds of students: while lectures on medical police were attended by medical students, lectures on forensic medicine were more likely to be attended by surgery students.[41] By the early nineteenth century, however, public medicine — including medical police and forensic medicine — became part of the compulsory curriculum. This change was introduced at the Faculty of Medicine in Vienna in 1804 and four years later also in Prague. Students thus had to take exams in medical police and forensic medicine in the final year of their five-year studies in medicine or two-year studies in surgery.

The success of state medicine and its practical implementation depended on the existence of a comprehensive system of health administration, and that had to have a solid basis in law. Reforms of healthcare, state administration, and higher education carried out in the second half of the eighteenth century by Empress Maria Theresa and her son Joseph II enabled the creation of a comprehensive system of health administration in the entire Habsburg monarchy. The leading architect of the gradual formation of a system of health administration and medical education was Gerhard van Swieten (1700-1772).

The reform of medical education included the creation of the office of director of studies at medical schools: this person was responsible for the administration of medical studies and was appointed by the government. This brought teaching under greater control of the provincial gubernia, that is, the

[40] Tinková (2022: 68-162).

[41] Archive of the Charles University, fonds Katalogy posluchačů Karlo-Ferdinandovy univerzity, inv. 257-271, sign. C165, kart. 83-84.

state authorities responsible for the administration of the province, which were responsible to the government in Vienna. There was created the office of provincial protomedicus (*Landschafts-Protomedicus*),[42] who was identical to the abovementioned director of studies at a medical school, but his office, protomedicate, was part of the provincial government, gubernium. In provinces where no protomedicus was appointed, a physician from the capital was to be nominated for this purpose; each of the protomedics was appointed as a medical councillor (*Rath*).

The director of medical studies at the University of Vienna was also the chief protomedicus of the royal and imperial hereditary lands. In this capacity, he had broader competencies that covered the entire healthcare system of the Austrian Empire. In relation to all medical matters in the Austrian monarchy, he was directly subordinate to the court chambers. At the same time, the protomedics of the individual provinces (lands) were subordinate to the protomedicate in Vienna. In each county (*Kreis*),[43] the position of a county physicist (*Kreisphysiker*) and county surgeon (*Kreischirurgus/Kreiswundarzt*) was established, whereby the surgeon was subordinate to the county physician, who in turn was subordinate to the county office and the provincial protomedicate. At the lower levels, this system included physicians and surgeons serving particular towns or estates (manors). Unlike persons at the higher levels of this hierarchy, these lower-ranking officials were not paid by the state. During the second half of the eighteenth and in the early nineteenth

[42] The institution of the Protomedicato was established in Spain as early as the late 15th century. In 1477, a royal edict came into force that created the *Tribunal del Protomedicato*. During the reign of Philip II, the institution underwent reforms in 1588 and 1593, becoming a legal-administrative body intended to function as a mechanism of political control. From its inception, the "Protomedicato" was tasked with supervising examinations and licensure for physicians, surgeons, midwives, and other medical practitioners, as well as related trades. Its officials—protomédicos—were empowered to sanction unauthorized practice, fine offenders, and prosecute so-called charlatans, who often relied on occult or superstitious methods (López Terrada, 1996). The principle of centralized medical oversight was subsequently transferred to the Spanish overseas territories during the sixteenth century. In the early phase of colonial expansion—when institutional infrastructure was still under development—the responsibility for appointing medical inspectors fell to the conquistadors themselves (Hernández, 2018). In some parts of the Austrian Empire, the post of a protomedicus had existed previously (for instance in Bohemia, it existed since late sixteenth century) but its role was significantly different (Anděl *et al.*, 2023).

[43] The reform of regional administration was carried out in 1751.

century, the competencies of the various professions were gradually clarified, and the system of state health administration thus consolidated.

The reform of medical education focused on standardisation: there were now certain compulsory medical textbooks and students had to follow the order of studies, which would be regularly updated.[44] All of this was further supported by legislation which stipulated that, in the Habsburg Monarchy, medicine could be practised only by persons who either obtained a medical degree from one of the universities in the empire or had at least been examined by a county physician.[45] It was moreover standard for medical practitioners to belong to a professional medical organisation. This was likewise regulated: in the case of physicians, by the relevant medical school, and in the case of surgeons, by the relevant surgical board.[46] All this led to the standardisation of the medical profession and thus to a standardisation of knowledge that the state could use. Crucially, this standardisation was underpinned by a hierarchical system and ultimately subordinated to administrative authorities. Medical professionals could thus be controlled through several structures within the health system. The system also included feedback mechanisms: because senior health officials had to submit regular inspection reports, communication was maintained not only from the centre to the lower levels of the hierarchy but also vice versa, which could lead to modifications of the rules and regulations.[47] In effect, the health reforms thus affected the medical profession and health administration before they had an impact on citizens themselves. It was a long and essentially constant process of adjustment and fine-tuning.

A reflection of these ambititons is the *Systematisches Handbuch des Medicinal-Wesens*, a textbook and handbook written by the aforementioned Johann Joseph Bernt, professor of *Staatsarzneikunde* at the Medical Faculty of Vienna.

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[44] Hlaváčková and Rozsívalová (1984).

[45] Such regulations can be found as early as the 1770s (cf., e.g., the court decree of 30 March 1770). Towards the end of the eighteenth century and in early nineteenth century, legislation came to cover an increasingly wide range of medical professions; see Hempel-Kürsinger (1830: 188-189); Bernt (1819: 6-7, 342-360). Naturally, the system did not always function smoothly and there were ways of circumventing it, especially in places where the state had limited access. Dozens and even hundreds of complaints lodged with regional and municipal administrations attest to frequent disputes between the various medical professions, to arguments over competencies, possibilities of action, etc. But individuals often try to use the legislation to achieve their goals.

[46] Bernt (1819: 165, 193, 204).

[47] Himl (2019).

In it, Bernt outlines the entire system of health administration that would guarantee that public health and disease prevention were supervised by state-trained professionals. Bernt systematically discusses the duties of the various professions, their responsibilities training, remuneration, and competencies.[48] He includes the installation and distribution of medical professionals and their auxiliary staff under the heading of "indirect protection of the population". Notably, he refers to them using the term *Polizey der Medizin*; if we understand *Polizey* to mean "order", it thus implies the administration of medicine or medical affairs.[49] This sphere of the *Staatsarzneikunde* was supposed to function as a support system for the implementation of measures aimed at the direct protection of the population, as a network of professionals and officials providing medical supervision and care within the intentions envisaged by the state.

This is followed by a description of the specific competences within medicine. In this, Bernt claims he was inspired by an approach first introduced in 1800 by the German politician and physician Benjamin Erhard in his treatise entitled *Theorie der Gesetze, die sich auf das körperliche Wohlsein der Bürger bezühen, und die Benutzung der Heilkunde zum Dienst der Gesetzgebung* (The Theory of Laws Concerning the Physical Welfare of Citizens and the Use of Medicine in the Service of Legislation). In the introduction to this work, Erhard discussed the theory of healthcare legislation, distinguishing between three basic types of rights, whereby medical legislation was to be derived from the so-called guardianship law… to feel comfortable, [people] must often join their forces, submit to uniform rules, and be protected by the state from harm and injury. According to this principle, we must therefore determine the objects of medical legislation (*medizinischer Gesetzgebung*).[50]

Nevertheless, medical legislation must meet two conditions: "firstly, whoever arrogates to himself the right to care for me must actually be in a position to care for me better than I can myself. Secondly, he must be able to compensate me if I follow his advice and suffer harm as a result".[51]

But, Erhard admits, this is a difficult task, because even people with little or no experience in healing often call themselves doctors. It is therefore necessary to provide a clear definition of empirically based medicine: when using the services of its practitioners, citizens would have a guarantee of its

48 Bernt (1819).
49 *Id.*; Liepoldová (2024).
50 Erhard (1800: 3-4).
51 *Ibid*: 5.

practitioners having a certain amount of knowledge. Erhard argues that the subject matter of laws relating to medicine includes two categories, namely the physical wellbeing of citizens (*das körperliche Wohl der Bürger*) and the institutions directly relevant to persons whose knowledge and skills are required by the legislator (in part to support the legislation and in part to protect the health of the citizens). Following this division, Erhard identifies three different areas that may be affected by the legislation: the medical police *(medicinische Polizey),* medical establishment or administration (*Polizey der Medizin*), and forensic medicine (*gerichtliche Arzneikunde*).

Competencies of the health police encompass all matters directly relevant to the physical wellbeing of citizens that do not depend on the individual citizens themselves. This sufficiently distinguishes them from the purview of criminal law. Furthermore, the health police is distinct from the administration of medical affairs (*Polizey der Medicine*), because

> …the police of medicine (*Polizey der Medicine*) serve the perfection of medicine. Medicine as a science is not the business of a particular country and government but the business of all mankind. Its perfection is an end in itself. It is not subordinate to the goals of the State; rather, it must be a goal of the State itself. The governing principle for the medical order is therefore none other than the highest perfection of medicine, and the State must act to that end as if it were its own end.

Erhard understood forensic medicine in a very narrow sense as a precise and accurate determination of the state of affairs through exercise of knowledge of medical science. Forensic medicine in itself cannot make any laws or lay down principles for judging a case: its task is merely to evaluate facts using medical science by presenting opinions.[52]

Erhard was thus the first to separate and define the competencies of the different areas of legislation related to medicine in theoretical terms and the first to state that the administration of health matters should be treated separately. Many eminent physicians whose main area of interest was medical police or forensic medicine (including Johann Stoll, who was medical councillor, *Medizinrat*, in the Grand Duchy of Hesse, J. F. Niemann, A. Reschlaub, and, of course, Johann Peter Frank) later built on his treatise or defined their position in relation to it.[53]

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[52] Erhard (1800: 112).

[53] This naturally does not mean that prior to Erhard there was not a discourse on medical administration and the need to correct it. In the Habsburg Empire, one such

For Bernt, Erhard's system was one of the models on which he based his textbooks for medical students. In these textbooks, too, he mentions the importance of separating the medical police from the administration of medical affairs, noting that "… in the first case [i.e. *medicinische Polizey*], medicine serves legislation, while in the second case [*Policey der Medizin*], the legislation serves medicine".[54] Bernt dedicated his textbooks to the individual categories outlined by Erhard, whereby the aim of his *Systematisches Handbuch des Medicinal-wessen* was to describe the functioning of the Habsburg medical administration.

Aside from the aforementioned hierarchical administration of medicine (introduction of the office of the chief and provincial protomedicus, the office of study directors, county physicists and surgeons, and the definition of their competences), the regulations described by Bernt in relation to medical administration (*Polizey der Medizin*) systematised also the training of medical personnel, examinations, licensing, duties, appointments to medical posts and activities, and the duties and rights of medical trainees and personnel. The aforementioned protomedics and their subordinate county physicists were responsible for controlling and supervising all matters concerning the health or illness of individuals. They were expected to submit reports, make suggestions, record incidents and notable events, and be active in efforts to implement measures and regulations pertaining to "the preservation and consolidation of life and health, or the development, cure and prevention of disease".[55]

They were also responsible for the control and supervision of medical institutions such as hospitals, dispensaries, maternity hospitals, foundling homes, shelters, in the entire range of medical care provided, including economic administration, building management, and the like. Moreover, the protomedics were tasked with the supervision of pharmacy, including the inspection of medicines, checks of pharmacies, and control of the establishment of new pharmacies. The provincial protomedicus was also responsible for appointing county physicians (*Kreisphysiker*) and surgeons who worked within the county offices. The county offices were, in turn, responsible for supervising the lower offices. The protomedicus, like the county physician, had to inspect his district annually and report on the state of health.

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thinker was for instance J. P. Fauken, who criticised both medical administration in general and the so-called Josephinum (a military surgical academy established during the reign of Joseph II) in particular. Cf. Fauken (1784, 1794).

54 Bernt (1819: 5-6).

55 *Ibid*.: 343-345.

Bernt's manual systematised the regulations and laws that built a hierarchical network of medical administration in the Habsburg monarchy from the mid-eighteenth century onwards, i.e., since the reforms introduced by Gerard van Swieten. From late eighteenth century onwards, there was thus in place a strong bureaucratic apparatus within which there was a constant bidirectional communication pertaining to requests, consultations, and clarification of competencies as a result of new regulations and measures. Thanks to the nature of this network, it was moreover possible to communicate about medical matters and implementation of state-wide healthcare measures such as smallpox vaccination.

IV. CONCLUSION

In the late eighteenth and early nineteenth centuries, one can observe a fundamental shift in the approach to managing public health. From early on, Central European governments and medical elites participated in this process, oftentimes with great enthusiasm and persistence. Issues related to health and the state of the population came to play a key role in the newly established "state" sciences: cameralism and police science.

In the Habsburg monarchy, the new approach to public health also led to the creation of a hierarchical system of medical administration, in which protomedics, county physicians, and other medical personnel provided supervision of public health and disease prevention. This system created a network of communication between the different levels of medical administration, which was supported and controlled by the state.

In the Habsburg Monarchy, these changes were reflected in the introduction of *Staatsarzneikunde* at medical schools. This course was created, among other things, in order to prepare future medical graduates for their possible role as civil servants, that is, medical professionals who would fulfil the need for a closer link between medicine and the civil service. As a result, medical professionals became key players in the administration and control of public health.

State medicine in the Habsburg monarchy brought about state-organised healthcare and supervision of the population. Medical professionals thus worked in close cooperation with the state administration, which in turn contributed to the elevation of the status of the medical profession. This integration contributed to the creation of the health system as we know it today, which was designed to meet the needs and interests of the state.

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